STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055697	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Costa Del Sol Healthcare	1016 S. Record St. Los Angeles, CA 90023

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45657 Based on observation, interview and record review, the facility failed to ensure three of eight sampled residents (Resident 2, Resident 5 and Resident 6) call lights were placed within residents' reach. This deficient practice could result in residents ' needs not met and residents ' highest practicable physical, mental, and psychosocial wellbeing will not be maintained. Findings: a). During an observation on 8/23/2024 at 3:10 p.m., in Resident 2 ' s room, Resident 2 ' s call light was observed hanging on the left side of Resident 2 ' s bedside wall. Certified Nursing Assistant (CNA) 1 came and took the call light from the wall and gave it to Resident 2. During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses of muscle weakness (loss of muscle strength), lack of coordination (problem with balance, movement, or coordination), and other abnormalities of gait and mobility (abnormal walking pattern). During a review of Resident 2 ' s History and Physical (H&P) dated 2/18/2024, the H&P indicated Resident 2 had the mental capacity to understand and make medical decisions. During a review of Resident 2 ' s Minimum Data Set ([MDS] a standardized care assessment and care screening tool), dated 5/31/2024, the MDS indicated Resident 2 ' s cognitive skills (thought process) usually understand and be understood by others. The MDS indicated Resident 2 required supervision or touching assistance with activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, transfer (moving between surfaces to and from bed, chair, and wheelchair) and bed mobility (how resident moves from lying to turning side to side). During a review of Resident 2 ' s care plan titled, High risk for fall related to generalized weakness, gait/balance, dated 2/18/2024, the interventions indicated to place resident ' s call light within reach and encourage the resident to use the call light. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055697	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Costa Del Sol Healthcare	1016 S. Record St. Los Angeles, CA 90023

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b). During an observation on 8/23/2024 at 3:35 p.m., in Resident 5 ' s room, Resident 5 was observed laying on bed. Resident 5 ' s call light was observed stucked on the right side of the of the bed rail away from Resident 5 ' s reach. When Resident 5 was asked where his call light was, Resident 5 stated he did not know where his call light was. During a review of Resident 5 ' s Admission Record, the Admission Record indicated Resident 5 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 5 ' s diagnoses included muscle weakness, other lack of coordination, and other reduce mobility. During a review of Resident 5 ' s H&P dated 8/6/2024, the H&P indicated Resident 5 had no mental capacity to understand and make medical decisions. During a review of Resident 5 ' s MDS, dated [DATE], the MDS indicated Resident 5 ' s cognitive skills were intact. The MDS indicated Resident 5 was dependent with ADLs such as dressing, toilet use, personal hygiene, transfer, and bed mobility. c). During an observation on 8/23/2024 at 3:40 p.m., in Resident 6 ' s room, Resident 6 was observed laying on bed. Resident 6 ' s call light was observed hanging on the right side of the bed away from Resident 6's reach. During a review of Resident 6 ' s Admission Record, the Admission Record indicated Resident 6 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 6 diagnosis included Parkinson Disease (disorder of the central nervous system that affects movement, often including tremors), other lack of coordination, and other reduce mobility (lack of walking pattern). During a review of Resident 6 ' s H&P dated 6/27/2024, the H&P indicated Resident 6 did not have the mental capacity to understand and make medical decisions. During a review of Resident 6 ' s MDS, dated [DATE], the MDS indicated Resident 6 ' s cognitive skills was intact. The MDS indicated Resident 6 was dependent with ADLs such as dressing, toilet use, personal hygiene, transfer, and bed mobility. During a review of Resident 6 ' s care plan titled, High risk for Activity of Daily Living (ADL) self-care performance deficit related to Parkinson Disease, gait balance problems, dated 3/30/2023, the interventions indicated to encourage resident to use call light for assistance. During an interview on 8/27/2024 at 12:36 p.m., with CNA 2, CNA 2 stated call lights must always be placed within the residents ' easy reach and should not be placed on any of residents ' side rails. CNA 2 stated residents can use the call light to call staff when they are in danger of falling, or when needing incontinent care to prevent skin breakdown. During an interview on 8/27/2024 at 3:36 p.m., with the Director of Nursing (DON), the DON stated when call lights are not within in a resident ' s reach, the resident could not call and could not get their needs met right away. During a review of the facility ' s policy and procedure (P&P) titled, Answering Call Light, dated 10/2010, the P&P indicated residents ' call lights should be within easy reach when a resident is in bed or confined to a chair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055697	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Costa Del Sol Healthcare	1016 S. Record St. Los Angeles, CA 90023

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45657 Based on observation, interview, and record review, the facility failed to ensure two of eight sampled residents (Resident 3 and Resident 4) who were on gastrostomy tube ([GT] a tube surgically inserted into the abdomen to administer medications and nutrition) feedings, received tube feedings (nutrition administered via GT) timely according to the physician ' s orders. This deficient practice had the potential to result in Resident 3 and Resident 4 ' s nutritional needs not met leading to weight loss and malnutrition (lack of proper nutrition). Findings: a) During an observation on 8/23/2024 at 3:25 p.m., in Resident 3 ' s room, Resident 3 was observed with GT feeding of Glucerna 1.2 calories (name of tube feeding formula) and a water bag with label, dated 8/23/2024 at 1:00 p.m., that was turned off. During a concurrent observation and interview on 8/23/2024 at 4:12 p.m., with Licensed Vocational Nurse 1 (LVN) in Resident 3 ' s room, Resident 3 ' s GT pump (machine used to deliver tube feeding) was turned off. LVN 1 reviewed Resident 3 ' s physician ' s order and stated, the GT feeding order had indicated tube feeding should have been turned on at 2 p.m. During a review of Resident 3 ' s Admission Record, the Admission Record indicated Resident 3 was admitted to the facility on [DATE]. Resident 3 ' s diagnoses included adult failure to thrive (decreased appetite and poor nutrition), diabetes ([DM]high blood sugar), and gastrostomy (artificial openings of digestive tract). During a review of Resident 3 ' s History and Physical (H&P) dated 3/25/2024, the H&P indicated Resident 3 did not have the mental capacity to understand and make medical decisions. During a review of Resident 3 ' s Minimum Data Set ([MDS] a standardized care assessment and care screening tool), dated 6/14/2024, the MDS indicated Resident 3 had intact cognitive skills (thought process). The MDS indicated Resident 3 was dependent with activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, transfer (moving between surfaces to and from bed, chair, and wheelchair) and bed mobility (how resident moves from lying to turning side to side). During a review of Resident 3 ' s physician's order dated 8/19/2024, the order indicated, Glucerna 1.2 (type of tube feeding formula) at 60 milliliters/hour (mL/hr.) for 20 hrs. to provide 1200 ml/ 1440 kilocalorie (kcal) every shift, on at 2:00 p.m., off at 10:00 a.m., or until dose is completed. b) During an observation on 8/23/2024 at 3:27 p.m., in Resident 4 ' s room, Resident 4 was observed with a GT feeding of Glucerna 1.2 and a water bag with label dated 8/23/2024 at 6:00 a.m. The GT was observed disconnected from Resident 4. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055697	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Costa Del Sol Healthcare	1016 S. Record St. Los Angeles, CA 90023

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 8/23/2024 at 4:05 p.m., with Licensed Vocational Nurse (LVN) 1, inside Resident 4 ' s room, Resident 4 ' s GT was observed disconnected from Resident 4 and was confirmed (GT disconnected) by LVN 1. During a review of Resident 4 ' s Admission Record, the Admission Record indicated Resident 4 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 4 ' s a diagnosis included adult failure to thrive, diabetes and gastrostomy status. During a review of Resident 4 ' s H&P dated 3/7/2024, the H&P indicated Resident 4 had the mental capacity to understand and make medical decisions. During a review of Resident 4 ' s MDS, dated [DATE], the MDS indicated Resident 4 had intact cognitive skills. The MDS indicated Resident 4 was dependent with ADLs such as dressing, toilet use, personal hygiene, and transfers and bed mobility. During a review of Resident 4 ' s physician's order dated 5/13/2024, the physician's order indicated Glucerna 1.2 at 65 ml/hr. for 20 hrs. to provide 1300 ml/ 1560 kcal., with water flush of 50 ml/hr. for 20 hrs. via kangaroo pump (type of tube feeding machine) daily, to start at 2:00 p.m., and stop at 10:00 a.m., or until dose is completed. During an interview on 8/27/2024 at 12:46 p.m., with LVN 1, LVN 1 confirmed Resident 3 ' s tube feeding was turned off and Resident 4 ' s tube feeding was disconnected. LVN 1 stated Residents 3 and 4 ' s tube feeding should have started at 2:00 p.m. per doctor ' s ' orders. LVN 1 stated when tube feedings were off, residents could suffer dehydration (loss of water), weight loss and malnutrition. LVN 1 stated diabetic residents could suffer hypoglycemia (low blood sugar levels). During an interview on 8/27/2024 at 1:45 p.m., with the Registered Nurse (RN), the RN stated charge nurses (LVNs) must follow physician ' s tube feeding orders. The RN stated tube feeding is the residents ' nutrition. The RN stated, it was not acceptable to start the GT feeding late than what was ordered. The RN stated the facility placed Resident 3 and Resident 4 at risk of losing weight, that could result in malnutrition. During an interview on 8/27/2024 at 3:36 p.m., with the Director of Nursing (DON), the DON stated it was important for the nurses to follow physician ' s tube feeding orders to meet residents ' nutritional needs. The DON stated not turning on the tube feedings on time could result in weight loss. During a review of the facility ' s policy and procedure (P&P) titled, Enteral Nutrition, dated 11/2018, the P&P indicated adequate nutritional support should be provided to the residents through enteral nutrition as ordered.